Consent for Medical Treatment

I hereby authorize and request ***North Shore Vein Clinics, LLC*** and its healthcare providers to provide such medical examination, testing and care and administer procedures and treatments as in the judgment of the healthcare providers deem advisable.

I hereby voluntarily consent to the rendering of medical care which includes such medical treatment as my healthcare provider or other consulting healthcare provider deems appropriate. I understand that I must look solely to the attending physician(s), and not other staff of ***North Shore Vein Clinics, LLC*** for interpretation of the results of any procedure or test, and medical treatment. I understand the nature and purpose of ***North Shore Vein Clinics, LLC*** medical treatment and am aware that medical complications can occur. I understand that I have the right to discuss the treatment plan and purpose, potential risks, and benefits of any test ordered for me or treatment provided. I understand that if I have any concerns regarding any test or treatment recommended by my health care provider, I have the right to ask my healthcare provider about the same.

I acknowledge that no guarantees have been made as to the result of treatment. I consent to other health care personnel in training being present during treatment and in some instances providing supervised treatment.

This consent provides ***North Shore Vein Clinics, LLC*** and its healthcare providers with my permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, I am indicating that (1) I intend that this consent is continuing in nature even after a specific diagnosis has been made, treatment recommended, and treatment provided; and (2) I consent to treatment at this office or any other affiliated medical practice office.

The consent will remain fully effective until it is revoked in writing. I understand that I have the right at anytime to discontinue receiving services with our office.

I consent to the taking of photographs at any point while I am undergoing treatment and to the use of those photos for scientific, educational or research purposes.

I, the undersigned, understand and agree to the above.

Patient/Guarantor June 09, 2020

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